The Hills
PRIVATE HOSPITAL
by Healthscope

Rehabilitation Referral

Attach patient identification label

Patient Details

UR Number: .....

Surname: .....

Name: .....

Date of Birth: ..... Gender: .....

Dr: .....

Referral for: ☐ Day Program ☐ Inpatient **Referral fax: 02 9639 5950 or email to rehabilitation.hills@healthscope.com.au**

TO BE COMPLETED BY THE REFERRER

Further details may be required on preadmission assessment.

Bed Manager will contact you about bed availability if the patient's suitability meets our rehabilitation criteria

Patient / Insurance Details

Address:			Post Code:
Tel (Home):		Mobile:	
Next of Kin:		Relationship:	Tel:
Referring Person:		Referring Hospital:	Ward:
Referring Hospital Admission Date:		Tel:	Fax:
Referring Specialist:		Previous patient at The Hills Private Hospital: ☐ Yes ☐ No	
GP:	Address:		Tel:
DVA: ☐ Gold ☐ White		Health Fund:	Membership No:
☐ Gold ☐ White	Insurance Co:	Claim No:	
Case manager:	Tel:	Fax:	Email:

Clinical Details

Diagnosis:				
Past Medical History:				
Allergies:	Recent ACAT Assessment: ☐ Yes ☐ No Details:			
Social History:	☐ Lives Alone	☐ Lives with Partner / Spouse	☐ Lives with Relative	☐ Lives with Carer
Type of Accommodation:	☐ Home / Unit	☐ Ret. Village	☐ Hostel	☐ Nursing Home
Premorbid ADL Status:	☐ Ind ☐ Assist	**Mobility:** ☐ Ind	☐ Assist ☐ With Aids	Type:
Community Services:	☐ SHN	☐ MOW	☐ Home Care	☐ Other
Current Mental Status:	☐ Alert ☐ Orientated	☐ Confused	☐ Known Wanderer	MMSE Score:
Current Mobility Status:	☐ Ind ☐ Sup	☐ Assist ___ Person(s)	☐ Min ☐ Mod ☐ Max	☐ With Aids: Type
Current Transfers:	☐ Ind	☐ Assist ___ Person(s)	☐ Min ☐ Mod ☐ Max	☐ Lifter
Current Self Care Status:	☐ Ind ☐ Sup	☐ Assist ___ Person(s)		
Current Continence Status:	**Bladder Cont.** ☐ Yes ☐ No ☐ IDC/SPC	**Bowel Cont:** ☐ Yes ☐ No	☐ Colostomy	☐ Ileostomy
Weight Baring Status:	☐ FWB ☐ WBAT	☐ PWB/TWB	☐ NWB	for _____ more weeks
Wounds:		**Type of Dressing & Frequency:**		
MRSA Screening: ☐ Yes ☐ No	**Site:**		**Result:**	
Other Instructions (eg. VRE, C Diff)	**Please State:**		**Site:**	
Diet:	☐ Normal ☐ Special	**Type:**		**NG / PEG /Jejunostomy**
Weight (Kgs):	**Bariatric Equipment Required:** ☐ Yes ☐ No		**COVID Vaccination Status:**	
02 Therapy: ☐ Yes ☐ No	**Requested Admission Date:**			

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Ward / Room:	Confirmed Admission Date:	
Clinical Program Type:	Specialist:	
Health Fund Financial Status: ☐ Yes ☐ No	Details:	By:

The Hills Private Hospital
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thehillsprivatehospital.com.au/rehabilitation/inpatient-rehabilitation
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